KNOXVILLE EYE SURGERY CENTER, LLC
Tennessee Valley Eye Center
140 Capital Drive, Suite 2
Knoxville, TN 37922

HIPAA: Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand and have been provided with a Notice of Privacy Policy that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

We will need to use your information to contact you with appointment reminders; do we have your permission to:

Leave message on answering machine? ___ Yes ___ No

Leave message with family member? ___ Yes ___ No

I fully understand and ❑ **accept** ❑ **decline** the terms of this consent.

STATEMENT BILLING: I understand I may receive 3 separate statements (bills) for my surgery in the event the procedure is not completely covered by my insurance. Each billing office is separate.

- 1 statement from your surgeon
- 1 statement from Knoxville Eye Surgery Center
- 1 statement from your anesthesia provider

_____ _____

Patient's Signature Witness Signature

_____

Date